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ABSTRACT

Designed to increase the reader's understanding of school-based clinics, this document begins by examining factors such as cost, age, scheduling, transportation, the need for confidentiality, and legal consent issues that hinder the adolescent's access to adequate health care. After reviewing early models of health care in schools, this document defines school-based clinics, outlines their recent growth, and lists their common characteristics. A profile of school-based clinics drawn from a 1987 mail and telephone survey, in which 35 of the 47 programs sampled responded, provides information on school-based clinic participants, staff, and services as well as the relationship between school-based clinics and the school, community, and school nurse. Last, school-based clinics are discussed in terms of components necessary for success, goals, funding, rationale for providing reproductive health care, involving parents and other adults, building links to other community-based providers, and current research to evaluate school-based clinics. Included are 3 tables, a list of operational sites by state, and a list of 16 printed resources. (CLA)

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School-Based Clinic

UPDATE 1987

by Sharon R. Lovick

The Support Center for School-Based Clinics
a project of
The Center for Population Options

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CPO and The Support Center

The Support Center for School-Based Clinics, a project of CPO, is a national resource for school-based clinics. Begun in 1985, the Support Center works to facilitate communication among SBC practitioners, assist in program development, consult on program operations, cooperate in the evaluation of the SBC model, assess public policy initiatives, and prepare for future developments in the field. The Support Center provides individual technical assistance, regional training, an annual conference, public policy analysis, publications, and a quarterly newsletter on program and policy developments.

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An Opening Word

As the SBC movement approaches its adolescence, even as we continue our role as a resource for emerging and established clinics and as an analyst for public policymakers, we find ourselves increasingly in the role of proponent and defender of SBCs, responding to more and more vociferous critics. As Director of the Support Center I have a perfect vantage point from which to view these developments, having frequently found myself in the hot seat recently.

This is probably an inevitable consequence of the growth and visibility of the SBC movement, something we might have predicted and certainly a problem we can handle. My concern is this: Will a fear of controversy move us to inaction? Will youth-serving professionals avoid reaching out to the teens most in need? Or if they do continue to respond to teens' needs, will they make incorrect decisions regarding their care in order to lessen the chance of conflict? Will we finally do nothing, assuming a battle will rage if we try? At a time when so many teens remain in need, it would be tragic if a few vocal critics succeeded in stopping a movement that has developed through the committed efforts of many communities and individuals.

This edition of the **Update** contains the information that will enable thoughtful individuals to understand school-based clinics in all their complexity. It explains what health needs adolescents have, how SBCs evolved to meet these needs, what SBCs are doing now, who uses them, how they fit into the larger network of family, school and community that seeks to serve adolescents. The **Update** confirms that programs can work, do work, are currently serving tens of thousands of teens across the country.

Advocates and practitioners can arm themselves with this information and continue their efforts to ensure that young people have access to the services they need, not the services some think they need.

Sharon R. Lovick

Are Teens' Health Care Needs Being Met?

Like other segments of the American population, adolescents have a variety of needs that must be met if they are to be truly healthy, or as the World Health Organization defines it: in "a state of complete physical, mental and social well-being." The report card points to a shocking lack of well-being among young people from a variety of causes. These are indicators that the health care needs of many teens are not being met.

Figures from the early 1980's show that nearly one-third of children age 6-16 had not visited a doctor in the preceding year and 15% had no regular source of medical care. Adolescents between the ages of 11 and 20 visited physicians' offices less often than did any other group although they had a higher rate of acute conditions (e.g., infections, influenza, injuries and the like). There are several factors that contribute to teens' lack of access to health care.

Economic factors are among the most important and the most obvious. The cost of health care is high, and increasing numbers of Americans are unable to afford it. Among children age 17 and under, more than one in five lived below the federal poverty level in 1985 and more than 40% of these poor children lived in families with incomes below half of the poverty level. Yet in 1986 only 46% of the poor or near-poor were covered by Medicaid because of extremely restrictive eligibility requirements. In that year approximately 12 million children had neither public nor private health insurance coverage. This figure seriously underestimates the number of children who do not have access to adequate health care: many insurance programs cover care only in the event of illness or hospitalization, leaving families responsible for routine physicals and well-child care as well as a portion of other medical expenses. Further, the number of un- and under-insured is increasing: in the public sector because federal budget cuts are restricting medical and social services and in the private sector because employers are reducing fringe benefits.

In addition to the economic factors limiting access to adequate health care, there are age-related factors peculiar to adolescence. According to a World Health Organization classification, teens suffer from four types of health problems that affect other age groups infrequently: those related to growth and development, risk-taking behavior and violence, sexuality, and the psychological transition to adulthood. The report card is testimony to the seriousness of these problems among American adolescents.

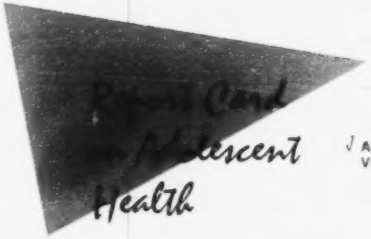
Intensifying these problems is the fact that some health professionals who treat adolescents are unprepared to deal with their special concerns. Furthermore, many have difficulty handling their own changing relationship with maturing patients, as parents become less and less involved in their care. The confidentiality that is often essential to successful treatment of adolescents may be jeopardized by the professional's past relationship

with the patient's parents.

Health care may not be accessible to teens for other reasons as well. Doctors' offices and clinics are often open primarily during school hours, with little provision made for after-school or weekend care. Transportation to the source of care is often a problem also, especially in rural areas and in cities without good public transportation. In recent years this problem has grown as more mothers work outside the home, and thus parents are less available to transport their children to doctors' appointments.

All of these difficulties are intensified when teens seek medical care independently of their parents. Scheduling, transportation, cost, the assurance of confidentiality and legal consent issues together may present insurmountable obstacles for adolescents, obstacles for poor and affluent teens alike.

The combination of economic and age-related factors limiting access to health care makes adolescents a particularly hard group to reach. Evidence of their unmet need for care is the fact that teens are the only group that has experienced an increase in mortality rate in the last twenty years. Clearly there is a critical need for better access to health care for adolescents.



✓ **TEEN PREGNANCY**	more than 1 in 10 teenage women get pregnant each year
	fewer than 1 in 10 teenage mothers completes high school
	nearly 8 in 10 families headed by single women under age 25 live in poverty
✓ **ACCIDENTS & VIOLENCE**	nearly 9,000 teens are killed each year in auto accidents
	over 3,000 teens are killed each year in other accidents
	over 2,000 teens are murdered each year
✓ **SUICIDE**	as many as 6,500 teenage suicides may be reported in 1987
	4 times that number may actually commit suicide
	10 times that number may attempt suicide
✓ **DRUG & ALCOHOL ABUSE**	drinking now begins on average at age 12
	10,000 young people are killed each year in alcohol related accidents of all kinds
	over 30% of 6th graders reported getting high on alcohol in the past year
	nearly 1/3 of seniors say most or all of their friends get drunk at least once a week
	60% of seniors have used an illicit drug
✓ **SEXUALLY TRANSMITTED DISEASES**	2.5 million teens are infected each year
	nearly half of all infected persons are under age 25

SBCs: Meeting The Health Care Needs of Adolescents

The Role of The School in Promoting Adolescent Health

Early Models of Health Care in Schools

Schools have long recognized the important link between health and education. In fact, they have been involved in student health care since the beginning of compulsory education in the United States. As early as 1840, school and health officials suggested that public schools play an active role in promoting student health. Early programs of school-based health services evolved to focus largely on the problem of infectious diseases and included vaccination and screening in order to prevent the spread of infection. During the first decades of this century, the school nurse became a fixture in many school systems, replacing or supplementing the transient physician. During this period communities experimented with a variety of approaches to meeting student health needs, including screening for correctable physical defects, immunization programs, and direct medical treatment. However, typical school health services were limited to health inspection, assessment, and first aid. Prevention and treatment were the responsibility of the private practitioner, and both school officials and the public saw health education as the primary role of the school nurse.

In the 1960's an increased national commitment to social services resulted in several federal programs that delivered health care to disadvantaged populations. In particular, communities throughout the country began to develop programs to serve adolescents. A number of innovative health programs developed during this period. One of the methods that evolved was an extension of, and in some cases a return to, health service programs available within the schools. One of the more successful of these programs is the school-based clinic (SBC).

The School-Based Clinic

School-based health clinics are primary health care centers located on the grounds of junior and senior high schools. Staffed by nurse practitioners and/or physicians, they are typically administered by organizations other than the school--hospitals, departments of public health, nonprofit agencies and community health centers.

The number of SBCs has grown phenomenally, from a single site in 1970 to 101 operating clinics in the fall of 1987. In the past year alone the number of clinic sites has increased by over 30%. Approximately 100 additional sites are currently being planned. SBC *sites* refers to individual clinics which are housed within, or adjacent to, school buildings. SBC *programs* refers to sponsoring entities which operate clinics. Some programs operate more than one SBC site in the same

community. The 101 existing clinics are part of 60 programs in 28 states. All share a core of common characteristics.

- SBCs are developed to meet the health needs of adolescents within a specific community.
- SBCs provide comprehensive primary health care services, including reproductive and mental health services.
- SBCs are located on school grounds, either in or adjacent to school buildings.
- SBCs are staffed by a multi-disciplinary group of professionals who choose to work with adolescents.
- SBCs maintain patient confidentiality while at the same time encouraging student interaction with parents and other adults.
- SBC's establish networks with existing community based resources to mobilize and maximize available services to teens.

TABLE 1 (N=51 Clinics)

Percentage Distributions of Different Ethnic Groups Seen in Clinics Per Month

Blacks Per Month(%)	Number/Percentage of Clinic Sites	
0-25%	22	43%
26-50%	5	10%
51-75%	5	10%
76-100%	19	37%
Total	51	100%
Whites Per Month(%)		
0-25%	34	66%
26-50%	7	14%
51-75%	5	10%
76-100%	5	10%
Total	51	100%
Hispanics Per Month (%)		
0-25%	38	74%
26-50%	6	12%
51-75%	2	4%
76-100%	5	10%
Total	51	100%
Asians Per Month(%)		
0-25%	51	100%
Total	51	100%
Other Groups Per Month(%)		
0-25%	47	92%
26-50%	1	2%
51-75%	2	4%
76-100%	1	2%
Total	51	100%

The SBC in 1987 - Survey Results

In March, 1987, the Support Center/CPO undertook a mail and telephone survey of the 47 programs that were then operating a total of 85 clinics throughout the United States. Of these, 35 programs operating 59 clinics (a 74% response rate) responded to a detailed questionnaire covering clinic activities and organization. On the basis of survey responses we have constructed a profile of these SBCs around the country.

The SBC Participant

Over 70,000 students are enrolled in schools in which SBCs are located. The median student body size is 1,750. Of this total school population, over 50,000 students are enrolled in SBCs, a participation rate of more than 71%. This finding underscores the frequent reports by individual clinics of extremely high participation rates. The vast majority of clinics serve only in-school students, although some (14%) also see drop-outs and a similar percentage see students from other schools. A few (1%) report seeing any adolescents in the target area; the children, siblings and parents of students; or school faculty and staff.

Clinic users reflect the racial and ethnic make-up of the total target school population (Table 1). However, the racial and/or ethnic make-up of each clinic's school is varied — some clinics are located in predominantly black schools, others are located in predominantly white or Hispanic schools. Of the students who use clinic services each month, an average of 36% are male and 64% are female (Table 2).

The SBC Staff

On average, clinics report having three paid positions and nearly three in-kind positions, either full or part-time. However, the range is large and varied. (Some programs have only one full time paid position, while other, larger programs may have as many as fifteen.) Survey responses indicate a diversity of staffing arrangements among clinics. Clinic staff are most likely to minimally include a nurse practitioner, a physician, and a counselor/social worker. A variety of other health and social service workers may staff SBCs, including a director or clinic manager, a health educator, a nutritionist, a receptionist, a clinic assistant, a dentist, a physician's assistant and a psychologist.

Many clinics piece together a staff from a number of resources. While this arrangement is not ideal, it does point to the fact that creative and flexible staffing allows SBCs to provide services that would not otherwise be available. The clinic staff is multi-disciplinary and especially suited, through training or interest, to working with adolescents.

During the first year of clinic operation, a full-time program administrator seems essential. The administrator acts as liaison between school and community, develops strategies for long-term funding, handles public relations and manages and assesses daily operations. A member of the clinical staff may assume the program administrator's responsibilities once the clinic is well established.

[redacted]

...mately 86% of the ... report the presence ... school nurse in the ...hool. In almost half of these, the school nurse works as part of the SBC staff, sometimes delivering primary care, more often coordinating a variety of essential follow-up activities. The school nurse also refers students to the clinic, participates in clinic staff meetings and case conferences, serves on program advisory boards, provides direct classroom education and staff in-service training, and aids in program development.

Survey responses indicate that the school nurse is not supplanted by the SBC; rather the clinic joins with the school health staff to enlarge the scope of services provided to students. School health services are coordinated with and integrated into the clinic operation. The school nurse serves as liaison between school and clinic. Clinic staff work with school nurses to expand the range of services available to students and facilitate their access to them.

TABLE 2 (N=52 Clinics)

Percentage Distributions of Males and Females Seen in Clinics Per Month

Males Per Month(%)	Number/Percentage of Clinic Sites	
0-25%	10	19%
26-50%	37	72%
51-75%	5	9%
76-100%	0	0%
Total	52	100%

Females Per Month(%)		
0-25%	0	0%
26-50%	7	13%
51-75%	37	72%
76-100%	8	15%
Total	52	100%

SBC Services

Each month the average clinic sees 204 students for a total of 1,372 visits. This average masks wide variations in both size and hours of operation. The smallest SBC serves only 20 students per month, the largest serves over 400.

Clinics offer a truly comprehensive range of services relating to the physical and emotional well-being of adolescents. Among these services are general health assessments, including sports physicals; laboratory and diagnostic screenings, including tests for pregnancy and sexually transmitted diseases; immunizations; first aid and acute care; sexuality education and family planning counseling and services; counseling and related mental health services; and health education. Additional services that SBCs may provide include dental care, prenatal and postpartum care, day care and medical care for children of students, drug and alcohol abuse counseling, nutrition counseling, job and career counseling, family counseling, and any other services needed by students and accepted by the community and the school. Table 3 presents the percentage of sites that provide each type of service.

Care related to reproductive health accounts for less than 25% of the total monthly services provided by SBCs, and a number of programs provide relatively little in the area of reproductive health care. However, program operators consider these services to be important to clinic operation, and 80% of respondents indicate that counseling on birth control methods, follow-up exams for birth control users, and pregnancy tests are an essential part of clinic services. A majority of programs (79%) do not dispense contraceptive methods.

The SBC in the School

The SBC is an integral part of the school environment. Physically, clinics are located within the school building (85%) or adjacent to it on school grounds (15%). The great majority of SBCs (80%) are open during the entire school day (40 hrs/wk). The remainder are open some portion of the school week, usually at least three days per week (24 hrs/wk). Nearly half (48%) maintain summer operations.

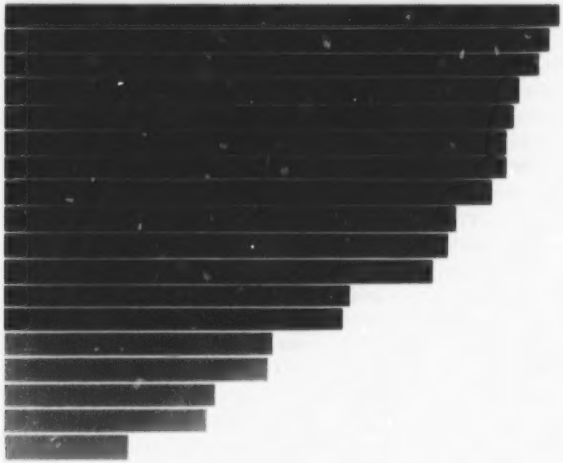
About 18% of SBC programs have evening, weekend or emergency coverage by SBC staff physicians, while an additional 38% arrange for coverage with a community or public hospital. After-hours care can be handled by clinic staff on a rotating basis or by arrangement with local health care providers. Since SBC users on the whole do not frequently require after-hours care except in emergencies, community hospital emergency rooms are often the source of care. Close ties between SBCs and other health care providers make students familiar with local providers and willing and able to use the larger system when the need arises.

The clinic staff, through a variety of activities, is familiar to the school population. The great majority of programs report that staff have important educational functions in the school: they make classroom presentations (91%) and conduct workshops, seminars and health fairs (79%). Many others report that clinic staff participate in school committees (44%), attend parent/teacher conferences (47%), and participate in the PTO/PTA (35%). Some clinic staffs, in conjunction with school personnel, conduct home visits and career counseling. These activities combined with the

TABLE 3

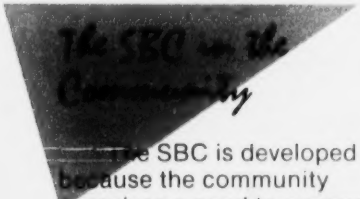
Percentage of Sites Providing a Range of Services

GENERAL HEALTH SERVICES



COUNSELING/EDUCATIONAL SERVICES

involvement of the school nurse (and school counselors where they are present) establish strong links between clinic and school.



The SBC in the Community

The SBC is developed because the community perceives a need to expand health care for adolescents. These programs often develop in areas of higher than average need. For example, clinic operators in our survey estimate dropout rates in their schools to be a bit higher than those for the district as a whole (23% vs 20%) and birth rates to teens in the community to be somewhat higher than those nationwide (18% of total births to teen mothers vs less than 14%). In 86% of the clinics surveyed, an advisory board meets periodically (on average 5 times per year) to develop policies for program operation and to act as liaison between the clinic and the community. Many advisory board-members serve as spokespersons for clinics and devote time to community outreach. A number of board members assist with fundraising activities.

Advisory boards always include representatives of the school system. Frequently they also include parents (97%), students (87%), health department representatives (76%), private physicians (70%), local church organizations (63%), and youth service organizations (60%). One-third of SBC advisory boards also include others, such as political figures, funding partners, clinic staff and social service and family planning agency representatives.

Clinic operators report that almost all SBCs are located in areas where there are other health and social service agencies that care for teens, including public health centers (90%), hospitals (40%), community-based and youth-serving organizations (30%), family planning agencies (25%), and other types of agencies (65%), such as drug abuse programs, counseling and mental health services and community centers. Recognizing that teens are only transiently in their care, fully 98% of SBCs report that referral to the community health care system is a frequent and important part of the services they provide.

The What, How & Why of SBCs

What Components Are Necessary for Successful SBCs?

► Our survey results and experiences with a variety of school-based clinic programs over the last three years point to five essential elements for successful operation of a SBC.

- A clear program policy statement must articulate the goals and objectives of the program.
- Specific services must be carefully planned so that they are consistent with program goals.
- Strong support within the school and the larger community must be developed and maintained.
- Programs need time to evolve, test strategies, and modify plans as they become responsive to the needs of local school populations. (It usually takes two years before a program is fully implemented.)
- Staff must be adequately trained to work within this special setting.

What Do SBCs Want To Accomplish?

► Most school-based clinics operate within the framework of a formal policy statement that sets specific goals for the clinic and relates individual services directly to the accomplishment of these goals. The Illinois Department of Public Health "School-Based Health Clinic Protocols" provides an excellent statement of the goals SBCs strive to accomplish:

> ... to improve student knowledge of preventive health care, provide early detection of chronic disorders and early treatment of acute health problems, improve decision-making about health matters, reduce risk-taking behaviors, develop health-promoting behaviors, provide preventive care, provide initial emergency treatment of injuries and illness with appropriate subsequent referral, detect signs of emotional stress and psycho-social problems for treatment, counseling or referral, facilitate students' use of health care systems by establishing links with primary health care providers, and promote continuing comprehensive health care for students of all ages.

How Do SBCs Build Linkages to Other Community-Based Providers?

► An important area of interaction among the SBC, school and community is in the links that are forged between health and social service providers and the young people who need their services. Most schools and communities maintain a number of important sources of care for adolescents. Unfortunately, teens have tended not to

use the available resources.

Because they are accessible, convenient, affordable, and comprehensive, SBCs are used by students. By making referrals and providing follow-up after student visits, the clinic staff facilitates access to the whole health care system, increasing the use of available resources and at the same time training young people to be knowledgeable consumers of the health care system. Thus SBCs become the hub of a network of organizations and agencies serving adolescents.

Why is Reproductive Health Care Included in SBC Services?

► Reproductive health care is an essential part of the services provided by the SBC. The serious negative consequences of teen pregnancy for both the teen parents and the baby are well-documented. The dangers to teens of sexually transmitted diseases (STD) are increasing. Programs encourage the delay of sexual activity, emphasize students' responsibility in their sexual activity and connect family planning and life planning decisions. Students learn that they are the ones who are ultimately responsible for maintaining their health and that attention to their reproductive system is an important part of total health care.

Because the clinic is in the school, students are available for counseling and follow-up over an extended period of time. In addition, sexuality education can be integrated into the classroom curriculum so that students can be encouraged to make decisions concerning sexual activity within the broader context of their future plans. Crucially, the programs provide students with the information and the resources to avoid unwanted pregnancy if they are sexually active. At a minimum, health care for sexually active teens includes family planning counseling, screening for STDs, referrals for contraceptives and follow-up for contraceptive users. In some clinics care can also include gynecological examinations, prescriptions and, where the community supports it, dispensing of contraceptives.

How Are Parents and Other Adults Involved?

► The SBC maintains patient confidentiality while encouraging adolescents to involve adults in their lives.

Parents are kept informed of clinic activities and are regularly involved in clinic planning and advisory groups. Clinics typically require written consent from parents in order for students to receive medical care. In most cases, consent covers all services available through the clinic and is not a condition for individual visits or treatments. In some clinics the consent form advises parents that state laws specifically prohibit clinic staff from informing parents of particular treatments. In a few sites the consent form allows parents to prohibit certain treatments.

The clinic staff recognize that at times teens' assessments of their own situation are not enough. Often the involvement of adults other than the clinic staff is crucial. Clinic staff strive to work together with parents, school counselors, nurses and administrators, and community health care workers to solve teens' problems and help families function.

How Are SBCs Funded?

► SBCs depend on a combination of public and private funds for their operation, usually in a 60% to 40% mix. The public dollars typically come from existing health care funding. On the federal level, funding comes in large part from the Maternal and Child Health Block Grant (MCH), through which states determine which local project to support. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Medicaid are increasingly being explored as potential SBC funding sources. In a few instances, states and localities have specifically set aside funds for SBCs. Private funding comes almost entirely from foundations. Corporations, non-profit organizations and private third party reimbursements or patient fees each contribute a small share.

The money available from private foundations is often short-term, granted for the duration of a pilot or demonstration project after which the program is expected to establish permanent funding from other sources. Increasingly, SBCs face formidable challenges to their continuing operation.

The encouraging news is that as policy makers and the public have become aware of the need for improved adolescent health care, many are taking action to provide funds for teen health programs. Legislation currently being considered in the U.S. Congress and in several states would provide funds specifically for SBC programs. A federal demonstration bill would provide $50 million to localities for each of four years. States such as Oregon, Michigan, and New Jersey have already passed legislation that earmarks funds for SBCs through demonstration programs or general authorizations. Minnesota and Maine have allocated money through health department budgets. State health departments, like those in Illinois and Missouri, are developing protocols and procedures in anticipation of an increased number of operational sites. Some cities have expressed interest in financing efforts to meet the health care needs of teens. Enlightened action by lawmakers and public agencies may continue the trend toward increased funding for school-based clinics.

What Are We Learning?

► In addition to the site information collected by the Support Center for School-Based Clinics, the Center for Population Options (CPO) is currently conducting a national research project to evaluate school-based clinics. CPO has collected and analyzed survey data from over 5,000 high school students in ten schools and has learned a great deal about the health care practices, personal habits, and risk-taking behaviors of adolescents across the country. Moreover, CPO has also learned a great deal about the services that school-based clinics are providing by analyzing actual clinic encounter data.

The research focused on five school-based clinics. Four have been in operation more than three years and one has been in operation less than three years. All are providing a wide range of services to the majority of students, 60%-83%, in each of the schools.

Of these five clinics, the largest one involved 10,752 encounters by 2,059 adolescents during one academic year. This is an average of five visits per person. These students are

using the clinics for a wide variety of reasons. The clinic encounter data revealed many of these reasons, including minor acute care (abdominal pain, sprains, acute stress reaction), laboratory tests (gonorrhea, pregnancy, pharyngitis) serious health concerns (asthma, obesity, hearing loss), and family planning services (contraceptive counseling, contraceptive methods, prenatal care or referral). They are also providing services to adolescents who require a great deal of care for such problems as suicide attempts, sexual abuse, and depression.

The student survey data indicated that the clinics that dispense birth control provide it to rather substantial percentages of sexually active students. In two of these clinic sites, 50% and 37% of the sexually active students have received a contraceptive method at the clinic. In addition, at another site, 41% of students indicated that they consider the clinic their regular source for getting birth control. Of those sexually active students in these sites, 47%, 46%, and 41%, respectively, obtained a method of birth control from the school clinic and used that method the last time they had intercourse. Further, sexually active clinic users are more likely to have used an effective method of birth control the last time they had intercourse compared to sexually active students in comparison schools without clinics.

The students who use the services of the school-based clinics further indicated that they use them because of their special characteristics, not because they are the only known clinics. The most common reasons given for using the clinics were: "it is part of the school and I trust it", "the staff really cares," and "it is easy to get to".

In summary, these data have demonstrated that school-based clinics are providing a wide range of health services to many adolescents. The Center for Population Options is continuing to conduct a rigorous evaluation of the impact of clinics on a variety of health related behaviors. CPO will be disseminating its findings in the summer of 1988.

A Final Word

The growth of school-based clinics over the past three years is extraordinary, from a mere 23 sites to the current 101 serving over 50,000 teens. The number of users alone suggests an important impact. The evidence that is beginning to accumulate of the significant difference SBCs make in the well-being of young people supports the impressions of those who have been closely involved with the programs.

Perhaps inevitably as the number of SBCs increases, as funding shifts to more public sources, as clinics become more visible, critics appear—vocal and adamant. Unfortunately, detractors are frequently misinformed, and clinic supporters must continue to educate them. Two recent misconceptions bear mentioning here.

First, even the most committed supporters have never considered SBCs the only solution for problems that all acknowledge to be complex and difficult to solve. A larger commitment to social services, job training and education programs are all essential to any long term solution to help youth. In the short term and in the area of adolescent health care, models other than the school-based clinic have had some success. All of these efforts should be encouraged. Not every community needs a school-based clinic; not every teenager in communities with a school-based clinic needs its services. This does not deny the appropriateness of SBCs where they exist nor negate the need for SBCs in other communities.

Second, SBC staff would never assume the prerogative of parents to educate their children regarding sexuality. Their goal is always to facilitate communication among children, parents and other adults. Several local surveys in different parts of the country indicate that large majorities of parents favor clinics that provide reproductive health care, as well as sexuality education, in schools. In many instances, the SBC or the school provides the crucial outreach that brings families together to talk about sexuality and reproductive health. In any case, those who are involved with SBCs are convinced that committed adults are adolescents' most essential resource.

The goal of SBCs is to help assure the well-being of adolescents by providing them with access to a whole range of health and social services. There are many young people throughout the country whose health and emotional needs remain unmet. Continued expansion in the number of new SBCs and in the effective operation of existing clinics holds the promise of providing for the well-being of many teens who are still in need.

Operational Sites

Arizona

California

Colorado

Connecticut

Delaware

Florida

Illinois

Indiana

Louisiana

Massachusetts

City of Cambridge
Neighborhood Health Center
17 Murdock St.
Cambridge, MA 02139
Sites: 1 HS

Holyoke Teen Clinic, Inc.
500 Beech Street
Holyoke, MA 01040
Sites: 1 HS

Maryland

Comprehensive School Health
Program
1211 Wall Street
Baltimore, MD 21230
Sites: 3 HS, 3 JH

Michigan

Hurley Medical Center
One Hurley Plaza
Flint, MI 48502
Sites: 1 HS

Benton County Health
Department
769 Pipestone
Benton Harbor, MI 49022
Sites: 1 HS

St. Clair County Health
Department
3415 28th Street
Port Huron, MI 48060
Sites: 1 HS

Muskegon Area Planned
Parenthood
1642 Peck Street
Muskegon, MI 48441
Sites: 1 HS, 1 MS

Minnesota

Minneapolis Health Department
250 South 4th Street
Minneapolis, MN 55415
Sites: 3 HS

Pilot City Health Center
1349 Penn Ave. N.
Minneapolis, MN 55411
Sites: 1 HS

Health Start Adolescent Health
Project
640 Jackson Street
St. Paul, MN 55101
Sites: 4 HS

Missouri

Adolescent Resources
Corporation
4010 Broadway, Suite 400
Kansas City, MO 64111
Sites: 3 HS

Mississippi

Jackson-Hinds Comprehensive
Health Center
4333 Medgar Evers Boulevard
Jackson, MS 39213
Sites: 4 HS, 1 JH

Montana

Lodge Grass Public Schools
Districts No. 2 and 27
Lodge Grass, MT 59050-0539
Sites: 1 HS, 1 MS

North Carolina

Greensboro School District
1900 Ashborough St.
Greensboro, NC 27406
Sites: 1 HS

Robeson County
Department of Health
Rt. 4 Box 388
Lumberton, NC 28358
Sites: 1 HS, 1 MS

New Jersey

Jersey City Medical Center
88 Clifton Place
Jersey City, NJ 07304
Sites: 2 HS

New Jersey Medical School
Department of Pediatrics
185 S. Orange Avenue
Newark, NJ 07103-2757
Sites: 1 HS

New Mexico

University of New Mexico
Department of Pediatrics
Surge Building
Albuquerque, NM 87131
Sites: 5 HS

Pecos Valley Medical Center
P. O. Drawer 552
Pecos, NM 87552
Sites: 1 HS

New York

Bronx-Lebanon Hospital
1650 Grand Concourse
Bronx, NY 10457
Sites: 1 HS

New York Medical College
Division of Adolescent Medicine
Munger Pavilion
Valhalla, NY 10595
Sites: 1 HS

School Health Demonstration
Program
Jamaica Hospital
8900 135th Street
Jamaica, NY 11418
Sites: 1 HS

North Shore University Hospital
Division Adolescent Medicine
300 Community Drive
Manhasset, NY 11030
Sites: 1 HS

Mt. Vernon Board of Education
100 California Rd.
Mt. Vernon, NY 10552
Sites: 1 HS

Mt. Sinai Hospital
Adolescent Health Center
19 East 101st Street
New York, NY 10029
Sites: 2 HS

Bedford Stuyvesant Family
Health Center, Inc.
1360 Fulton Street, 5th Floor
Brooklyn, NY 11216
Sites: 1 HS

Center for Population & Family
Health
Columbia University
60 Haven Avenue, Floor B-3
New York, NY 10032
Sites: 2 JH

St. Luke's Roosevelt Hospital
428 West 59th Street
New York, NY 10091
Sites: 2 HS

William F. Ryan
Community Health Center
160 West 100th Street
New York, NY 10025
Sites: 2 HS

Ohio

Cleveland Student Health
Program
1001 Huron Rd.
Cleveland, OH 44115
Sites: 1 HS

Oregon

Eugene School District 4-J
200 N. Monroe
Eugene, OR 97402
Sites: 1 HS

Eastern Oregon State College
School of Nursing
La Grande, OR 97850
Sites: 1 HS

Jackson County
Health Department
1313 Maple Grove Drive
Medford, OR 97501
Sites: 1 HS

Lincoln County
Health Department
255 S. W. Coast Hwy
Newport, OR 97365
Sites: 1 HS

Multnomah County
Health Department
426 Southwest Stark
Portland, OR 97204
Sites: 4 HS

Pennsylvania

Greater Philadelphia
Health Action
4510 Frankford Ave.
Philadelphia, PA 19124
Sites: 1 HS

South Carolina

Denmark-Olar School District
P. O. Box 345
Denmark, SC 29402
Sites: 1 HS

Tennessee

Memphis and Shelby County
Health Department
814 Jefferson Ave.
Memphis, TN 38105
Sites: 2 HS

Metropolitan Health Department
311 23rd Ave. North
Nashville, TN 37203
Sites: 1 HS

Texas

West Dallas Youth Clinic
Children & Youth Project
3131 N. Hampton Road
Dallas, TX 75212
Sites: 1 HS

Urban Affairs Corporation
2815 Reid Street
Houston, TX 77026
Sites: 1 MS

Virginia

Planning Council
130 W. Plume St.
Norfolk, VA 23510
Sites: 1 HS

Wisconsin

Milwaukee Comprehensive
Community Health, Inc.
1747 N. 6th St.
Milwaukee, WI 53212
Sites: 1 HS

Sources & Resources

Education Week.

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Division of Sexually Transmitted and STD Laboratory Programs, Annual Report: Fiscal Year 1985.

Black and White Children in America: Key Facts.

A Children's Defense Budget: FY 1988.

Education Week.

Promoting Adolescent Health: A Dialogue on Research and Practice.

School-Based Clinics: A Guide to Implementing Programs.

The Health of America's Children: Maternal and Child Health Data Book.

Building Health Programs for Teenagers.

Sex Education Coalition News.

Monitoring Children's Health: Key Indicators.

The Washington Post.

Educational Horizons, 65.

Statistical Abstract of the U.S.: 1987.

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